Name Of Insurance Company
To Which Application is Made: _____
(*herein called the Company*)

APPLICATION FOR HEALTHCARE FACILITY
PROFESSIONAL & COMMERCIAL GENERAL LIABILITY INSURANCE

Instructions:
1. Please type or print clearly.
2. Answer ALL questions completely, leaving no blanks. If any questions or part thereof, do apply, print "N/A" in the space.
3. If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.
4. This form must be completed, dated and signed by a principal of your facility.

I. GENERAL INFORMATION

Producer Name: _____

Address: _____
Street City State Zip

Telephone Number: _____
(Area Code) Number

Applicant's Name: Shelby County Government D/B/A The Memphis and Shelby County Health Department

Business Address: 814 Jefferson Ave., Memphis TN 38105
Street City State Zip

Mailing Address: 814 Jefferson Ave., Memphis TN 38105

Years In Business: 179 Employer Federal Tax I.D No.: 62-6000-841 Telephone No: 901-544-7582

Requested effective date: 2/28/08 Retroactive date: 2/28/03

Current Form Of Insurance: Professional Liability: ☐ Occurrence ☒ Claim-made
Commercial General Liability: ☐ Occurrence ☐ Claim-made

Applicant is a:
☐ Corporation ☐ Partnership
☐ Partnership Association ☐ Sole Proprietorship
☐ Joint Venture ☒ Other (*Please Explain)* Government

Applicant operates: ☐ For Profit ☒ Not for Profit

Limits of Liability
☐ $100,000/$300,000 ☐ $200,000/$600,000
☐ $500,000/$1,000,000 ☒ $1,000,000/$3,000,000 ☐ Other _____
**Professional Liability and General Liability Limits must be the same, but apply separately.*

Deductible (*applies separately to Professional Liability and General Liability*)
☐ None ☐ $5,000 ☐ $25,000
☐ $2,500 ☐ $10,000 ☒ Other Current $50,000

List below all subsidiaries, date acquired, and description of operations & ownership in percentages

Subsidiaries	Date Acquired	Description of Operations	% Ownership
N/A			

II. PROFESSIONAL LIABILITY

1. Services Provided: Indicate all services provided by your facility, giving requested information for each classification. Information given should be projected numbers for the next 12 months. "Visits" are defined as the number of patients entering your facility for health related services. DO NOT tally the number of departments visited or the number of procedures or treatments performed. "Beds" are defined as the average number of occupied beds.

Laboratory	Current Year Annual Receipts	Projected 12 Months Annual Receipts
X- Ray/Imaging	1,732 radiographs	1,890 radiographs
Mobile X- Ray/Imaging	1,297 radiographs by contract	1,450 radiographs
Other (Please Specify):	-	-

Surgical Center	Current Year # of Procedures	Projected 12 Months # of Procedures	Overnight Beds
Emergicenter	N/A		
Surgicenter	N/A		
Urgicenter	N/A		

Schools for Health Care Providers	# of Students	# of Faculty
Chiropractic	0	0
Dental	0	0
Medical	16	0
Nursing	85	0
Other (*please describe*): Medical Assistant	2	0

Outpatient Clinic	Current Year # of Outpatient Visits	Projected 12 Months # of Outpatient Visits	Current Year # of Beds
Multi-specialty	N/A	-	
Other (*please describe*): Public Health Medical Treatment Contacts	166,130 through 11/14/07	189,863 Calendar Year 2007 projected	

Organ Banks	Current Annual Receipts	Projected 12 Month Annual Receipts
Organ or Tissue Procurement Center: No direct processing or contact	N/A	
Organ or Tissue Procurement center: Direct processing or contact	N/A	

Rehabilitation Center	Current Year Outpatient Visits	Projected 12 Months Outpatient Visits	Beds
Cardiac Rehabilitation	N/A		
Physical or Occupational Rehabilitation	N/A		
Trauma Rehabilitation Therapy	N/A		
Transitional Living	N/A		
Skilled Medical	N/A		

Treatment Center	Current Year Outpatient Visits	Projected 12 Months Outpatient Visits	Beds
College or University Health Centers	N/A		
Community Health Centers	N/A		
Crisis Stabilization	N/A		
Mental Health & Counseling Services	N/A		
Municipal Health Department - Medical Treatment contacts	166,130 through 11/14/07	189,863 Calendar Year 2007 projected	0
Other (*please describe*)			0

See **ATTACHMENT A – CALENDAR YEAR 2007 MALPRACTICE INSURANCE REPORT** for detailed accounting of encounters reported for 2007.

2. Professional Employees/Independent Contractors. Please provide information requested for each physician/ surgeon providing services at your facility.

Medical Director* Name	**Specialty**	**Insurance Carrier & Policy Number**	**Type of Surgery** **	**Procedures/ Month*****	**Employee/ Contractor**	**Hours/Month**
Helen G. Morrow, M.D.	Pediatrics	State Volunteer Mutual Ins. Co. 89-F265	N/A		Employee 1.0 FTE	
Other Physicians & Surgeons Names	**Specialty**	**Insurance Carrier & Policy Number**	**Type of Surgery**	**Procedures /Month**	**Employee/ Contractor**	**Hours/Month**
Banani Dirghangi, M.D.	Pediatrics	State Volunteer Mutual Ins. Co. 89-F268	N/A		Employee 1.0 FTE	
Aglae K. Economides, M.D.	Pediatrics	State Volunteer Mutual Ins. Co. 89-K490	N/A		Employee 1.0 FTE	
Francis Fountain, M.D.	Public Health	State Volunteer Mutual Ins. Co. 89-4267	N/A		Employee 1.0 FTE	
Cynthia King, M.D.	Infectious Disease	State Volunteer Mutual Ins. Co. 92-3809	N/A		Employee 1.0 FTE	Effective 8/2007
John B. Kirkley, M.D.	Public Health	State Volunteer Mutual Ins. Co. 89-F265	N/A		Employee 1.0 FTE	Ending 9/2007 (Tail coverage thereafter)
Cuong Trinh, M.D.	Family Practice	State Volunteer Mutual Ins. Co. 89-F257	N/A		Employee 1.0 FTE	Ending 11/2007 (Tail coverage thereafter)

***A PHYSICIAN WILL ONLY BE COVERED IN HIS/HER CAPACITY AS A MEDICAL DIRECTOR FOR ACTIVITIES RELATING TO ADMINISTRATION OF THE FACILITY.**

******Surgery Definitions:

No Surgery – No surgery procedures performed other than circumcisions, incision of boils and superficial abscess or suturing of skin and superficial fascia. Includes closed fractures of the fingers and toes.

Minor Surgery –Assisting in surgery on physician's own patients, including closed bone fractures, except those of the fingers and toes, and D&Cs or vasectomies performed under local anesthesia.

Major Surgery – Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen pelvis; any other operation which, because of the condition of the patient or length or circumstances of the operation presents a distinct hazard to life. It also includes removal of tumors, open bone fractures, amputations, abortions, cesarean sections, the removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies and any operations done using general anesthesia.

*******Procedures- Indicate the number of times per month, on average, each doctor performs the following techniques. Gives total number for all procedures:

Acupuncture-other than anesthesia

Angiography

Arteriogrphy

Catherization- arterial, cardiac, or diagnostic, other than:

a) Occasional emergency insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers.
b) Urethral catherization
c) Umbilical cord catherization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen

Colonoscopy/Sigmoidoscopy
Cryosurgery-other than use on benign or premalignant dermatholgical lesions
Discograms
ERCP (Endoscopic retrograde cholangiopancreatography)
Lasers-used in therapy
Lymphangiography
Myelography
Needle biopsy-including lung and prostate but not including liver, kidney or bone marrow biopsy
Pneumatic or mechanical esophangeal dilation (not with bougie or lolive)
Pneumoencephalography
Radiation therapy
Radiopague due injections into blood vessels, lynphatics, sinus tracts and fistulae
Shock Therapy

NOTE: If any physician/surgeon is to be provided coverage under this policy, a supplemental application must be completed and an additional charge will be applied

3. Other Health Care Professionals. Indicate the number in each category, full-time and part-time

	Employees Full Time – Part Time	**Contractors Full Time – Part Time**	**Volunteers Full Time – Part Time**
Dentists	4 FT		
Emergency Medical Technicians	N/A		
Nurse Anesthetists	N/A		
Nurse Midwives	N/A		
Nurse Practitioners/Clinicians	14 FT		
Occupational Therapists	N/A		
Oral Surgeons	N/A		
Physical Therapists	N/A		
Physician Assistants	N/A		
Psychologists	N/A		
RNs/LPNs/LVNs	147 FT		
Social Workers	10 FT		
Technicians	Xray Tech – 2 FT Lab Techs – 16 FT (7vac)		
Other (Dental hygienists)	13 FT		

4. Do you currently comply with any state licensing requirements for your facility? **x** Yes ☐ No
If yes, describe. If no, state reasons for non-compliance and corrective actions being taken. CLIA, Tennessee Laboratory Licensure

5. Is the facility a member of any professional organizations or associations? **x** Yes ☐ No
If yes, please name: TN Public Health Association; National Association of County and City Health Officials; Chief of Dental -American Dental Association; National Dental Association; Director, Health Officer and Chief of Nursing are members of American Public Health Association; Health Officer is also member of American Academy of Pediatrics, Memphis & Mid-South Pediatric Society; laboratory has membership with the American Industrial Hygiene Association; Many employees are members of TPHA, ASM, NEHA.

6. Is the facility accredited by any governmental body or other organization (JCAHO, CARF, AAAHC)? ☐ Yes **x** No

x No Accreditation available
☐ Accreditation available, facility not accredited

If yes, please describe and include a copy of the accreditation report. _____

7. Do you have written requirements that the following providers carry Professional Liability Insurance? Please indicate the limits required.

	Yes	**No**	**Limits**
Physicians	X		$1,000,000 / $3,000,000
Surgeons			
Oral Surgeons			
Dentists	X		$1,000,000 / $3,000,000
Nurse Anesthetists			
Nurse Midwives			
Other (define)	X		Nurse Practitioners $1,000,000 / $3,000,000 as are all employees for medical/dental visits

8. Has any outside organization (JCAHO, government, insurance company) conducted an inspection of your facility within the past 3 years? **X** Yes ☐ No

If yes, please indicate the name of the organization and type of inspection (physical plant, nursing protocols) and include a copy of the report.

Name	**Type of Inspection**
State of Tennessee	Various audits
Memphis Managed Care	MCO inspections
United American Healthcare	MCO inspections

RISK MANAGEMENT/LOSS CONTROL

1. Does your facility have a formalized Risk Management Program? **x** Yes ☐ No

2. Who coordinates your Risk Management Program?

   Name: Cynthia Lawrence

   Title: Quality Management Coordinator

   Phone Number: 901-544-7516

3. Does the facility own any biomedical or other equipment used for diagnosis, monitoring or treatment purpose? **x** Yes ☐ No

   If yes, who is responsible for inspection and maintenance of the equipment?

   x Employees **x** Independent Contractor

   Do qualified personnel inspect and maintain the equipment on a regular basis? **x** Yes ☐ No

   Are manufacturers recommendations followed for all maintenance and repair of equipment? **x** Yes ☐ No

4. Do you have any contractual agreements with independent contractors/providers to provide services at your facility? **x** Yes ☐ No

   If yes, please provide a copy of a sample contract.

   Are certificates of insurance obtained from all contracted providers? **x** Yes ☐ No

5. Does the facility provide service to others on a contractual agreement? **x** Yes ☐ No

   If yes, please describe services provided and include a copy of the contract. TN Department of Health – various grants and contracts, State of TN – various grants and contracts, Shelby County and City Housing Lead Programs, United Way HIV nutrition (through summer 07), various MCO contracts, TennCare Dental contract, School nursing, School dental sealants, APHL for USPS BDS lab testing.

6. Has the facility agreed to hold harmless or indemnify others under contract? ☐ Yes **x** No

   If yes, please describe and include a copy of the contract. _____

7. Does the facility rent or lease any biomedical or other equipment? **x** Yes ☐ No

   If yes, please describe: Microscan analyzer and copy machines

8. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:

   x Check of educational background, or residency program, when applicable.

   x Check of previous employers ☐ In writing **x** By telephone

   x Check of personal references ☐ In writing **x** By telephone

   x Check on hospital privileges for physicians, oral surgeons and dentists

   How often do you update your list of specific privileges? Annually

- x Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
- x Require information on any professional liability or work-related claim that has previously been made against any individual.

9. Does your facility have written job descriptions? x Yes ☐ No

III. COMMERCIAL GENERAL LIABILITY INFORMATION

1. Please provide physical plant information as requested:

Address/Occupancy	Square Footage	Age	Type of Construction	# of Floors	Type Fire Protection*
Patient Care Buildings					
814 Jefferson Ave.	133,110	48	Brick	6	A,H,S.AS-6th floor
167 Washington, Collierville	1500	6	Metal	1	A,H,S
757 Galloway	18,750	34	Metal	1	A,H,S, AS-warehouse
6590 Kirby Center Cove	8,432	18	Brick	1	A,H,S
8225 Hwy 51 N. #11	1,200	19	Brick	1	A,H,S
3040 Covington Pike	4,000	25	Brick	1	A,H,S
6170 Macon Road	5,400	22	Brick	1	A,H,S
1287 Southland Mall	5,266	40	Brick	1	A,H,S, AS-kitchen
1064 Breedlove	9,000	39	Brick	1	A,H,S
1362 Mississippi Blvd.	8,809	39	Brick	1	A,H,S
1000 Haynes	11,134	32	Brick	1	A,H,S
2500 Peres	12,728	7	Brick	1	A,H,S, AS-kitchen
602 W. Mitchell Rd.	7870	30	Brick	1	A,H,S
451 Linden	5350	44	Brick	1	A,H,S
842 Jefferson Ave. (4th floor rm 405, 432, 5th floor rm.)	3,308	62	Brick	6	A,H,S
1075 Mullins Station Rd. (2nd flr, rm 200–235, 268)	17,920	@72	Brick	2	A,H,S

Other Buildings	Square Footage	Age	Type of Construction	# of Floors	Type Fire Protection*
Vector Control 2480 Central Ave.	15,176	38	Brick	1	none
Regional Forensic Center 1060 Madison Ave.	26,192	81	Brick	4	A,H,S
8336 Ellis Rd.	1100	41	Block	1	A,H,S
8334, 8340 Ellis Rd.	2300	41	Block	11	none

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

See **ATTACHMENT B – MSCHD MALPRACTICE INSURANCE COVERAGE SITES** for a detailed listing of all coverage sites.

2. Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest
*		

***See ATTACHMENT C – ALL ADDITIONAL PROFESSIONAL PERSONNEL CURRENTLY COVERED UNDER THIS PROGRAM** for a detailed listing of all nurse practitioner positions.

3. Do you sell or lease any medical equipment or products to patients or others in connection with your operation? ☐ Yes **x** No

If yes, please complete the following information:

Total Annual Sales: $ _____

Total Annual Lease/Rental Receipts: $ _____

Category I. EXPENDABLE ITEMS – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)

Annual Sales: $_____

Category II. NON-EXPENDABLE ITEMS – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc. and prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.

Annual Sales: $_____ Annual Lease/Rental Receipts: $ _____

Category III. DIGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or

equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.

Annual Sales: $ _____ Annual Lease/Rental Receipts: $ _____

Category IV. LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDA monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.

Annual Sales: $ _____ Annual Lease/Rental Receipts: $ _____

Have any of the products that you distribute ever been recalled? ☐ Yes ☐ No

4. Do you provide preventive maintenance or repairs on medical equipment leased to others? ☐ Yes **x** No

If yes, please provide details: _____

_____

V. POLICY AND LOSS INFORMATION

1. Please provide past policy information as requested. List all Commercial General Liability and Professional Liability policies for each of the past five years. Begin with the current policies on the top line.

	Policy Period	Insurer	Policy Limits	Deductibles	Total Premium	CM or Occ
Commercial Professional Liability	2/28/07-08	ACE	1,000,000 / 3,000,000	50,000	81,900 + tax	 CM
Commercial General Liability Professional Liability	2/28/06-07	ACE	1,000,000 / 3,000,000	50,000	79,500 + tax	Occ & CM
Commercial General Liability Professional Liability	2/28/05-06	ACE	1,000,000 / 3,000,000	10,000	52,000 + tax	Occ & CM
Commercial General Liability Professional liability	2/28/04-05	ACE	1,000,000 / 3,000,000	10,000	40,811 + tax	Occ & CM
Commercial Professional Liability	2/28/03-04	CNA/Columbi Casualty	1,000,000 / 3,000,000	10,000	37,000 + tax	Prof Only - CM
Commercial General Liability Professional Liability	2/28/02-03	NSO program through CNA	1,000,000 / 3,000,000 Individual certificate per employee	N/A	RN 89.00 each NP 348.00 each	Occ.

If claims-made, indicate retroactive date.

2. Are you aware of any circumstance, accident or loss which has occurred after the retroactive date, which may result in a claim? ☐ Yes **x** No

If yes, provide complete details. _____

_____

3. Have any claims ever been made against you? x Yes ☐ No

If yes, please give dates, allegations and disposition of each claim or suit in the comments section.
See **ATTACHMENT D-1 and ATTACHMENT D-2**

4. Has the facility ever had any Insurance Company or Lloyd's Syndicate decline, cancel, refuse to renew or accept only on special terms any Professional Liability Insurance?
NOTE: MISSOURI APPLICANTS DO NOT RESPOND x Yes ☐ No

If yes, please provide explanation: Insurance carrier discontinued providing coverage for nurses. This was a change in industry practice.

VI. FACILITY SPECIFIC INFORMATION

REHABILITATION FACILITIES *N/A*

1. Are patients referred to you by a physician? ☐ Yes ☐ No

If no, please describe referral procedures: _____

2. What is the length of the orientation and training period for new employees and volunteers? _____

Does it include training for the proper use of equipment and special training for high tech areas? ☐ Yes ☐ No

INPATIENT FACILITIES *N/A*

1. Was the facility designed or built for this occupancy? ☐ Yes ☐ No

If no, what was the original occupancy? _____

2. What is the construction? _____ Fire Protection Class? _____ Number of Stories? _____

3. How many exits per floor?

4. Are the electrical, heating and plumbing systems up to code and regularly inspected? □ Yes □ No

FIRE PROTECTION *N/A*

Are there smoke detectors and fire extinguishers? ☐ Yes ☐ No

Number and Location: _____

Is the building completely sprinklered? ☐ Yes ☐ No

If partially sprinklered, identify those areas that are sprinklered: _____

Are there fire alarms? ☐ Yes ☐ No

Number and type (local, central station, etc.): _____

1. Are there evacuation plans posted and drills held regularly? □ Yes □ No

2. Are there non-slip surfaces in bathing areas and handrails? □ Yes □ No

3. How are the beds licensed? (nursing home, ambulatory facility, etc.)

4. What is the minimum number of staff on duty at night?

5. What level of care is provided for the beds maintained?

   Is skilled nursing care provided including medication administration, injections, catherizations or other procedures ordered by physicians? ☐ Yes ☐ No

   Is assistance with daily living activities and some medication administration provided but no skilled nursing care? ☐ Yes ☐ No

   Are patients responsible for their own medication but some daily living activities planned, such as meals and social activities? ☐ Yes ☐ No

6. Do you provide residential care to children or adolescents? □ Yes □ No

Please include the following information with the completed application:

1. Previous Insurance Company loss runs for the past five years.
2. Current audited financial statement.
3. Brochures, pamphlets or other advertising material utilized by your facility.
4. Copies of any inspection reports/surveys conducted by outside organizations within the past three years.
5. Copies of any contracts for professional services provided to your facility or by your facility.

THE UNDERSISGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM

INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."

NOTICE TO LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY" (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

APPLICANT

Name of Applicant: SHELBY COUNTY GOVERNMENT DBA MEMPHIS AND SHELBY COUNTY HEALTH DEPARTMENT

Title: Director, Memphis and Shelby County Health Department

Signature: Original signature on file

Date: 11/16/2007

AGENT OR BROKER

Agency: _____
Name

_____
Address

_____

Agent: _____
Print Name

Signature: _____

Date: _____

CALENDAR YEAR 2007
MALPRACTICE INSURANCE REPORT

PROGRAM	# ENCOUNTERS
IMMUNIZATION ONLY	37,934
TB	38,581
JAIL - TB	929
STD CLINIC - 814 JEFFERSON	15,297
JAIL -STD	8,749
STD OUTREACH -HIV TESTING	288
EPSDT	9,923
FAMILY PLANNING	11,973
CSS - Clinic	3,349
CHILD HEALTH	2,458
WOMENS HEALTH	4,148
ADULT HEALTH	2,233
INT. TRAVEL SHOTS	740
NUTRITION - RW	110
EPIDEMIOLOGY	304
WIC ONLY W/MED. COMPONENT (LAB,IMM)	32,275
NP VISITS - PRIMARIES (Med. Tx Contacts)	9,811
LAB - DNA	1,919
FAMILIES FIRST	0
CAMPAIGN HEALTHIER BABIES	0
NEWBORN SCREENINGS	0
HEALTHY START*	0
LEAD PROGRAM	250
SCHOOL HEALTH*	1,500
EMPLOYEE HEALTH	7,069
OEP - Shelter	23
TOTAL	**189,863**

We are not requesting coverage on this policy for our Dentists as they have coverage under a separate policy.

Dental Program	Encounters
DENTAL - SCHOOL HEALTH	8,756
CLINIC DENTAL	2,149
Total Dental	**10,905**

RFP #08-011-32

ATTACHMENT B

MSCHD MALPRACTICE INSURANCE COVERAGE SITES

Main Offices at 814 Jefferson Avenue	Clinics	Field Sites
MSCHD Main Office Memphis, TN 38105	Bisson Health Loop* 602 W. Mitchell Rd. Memphis, TN 38109	Vector Control 2480 Central Ave. Memphis, TN 38104
Employee Health Clinic Room 212	Cawthon Health Loop* 100 Haynes. Memphis, TN 38114	Forensic Center 1060 Madison Ave. Memphis, TN 38104
Children's Special Services Room 112	Guthrie Health Loop* 1084 N. Breedlove. Memphis, TN 38107	Shelby County Schools Various Schools
Immunization Clinic Room 216	Hollywood Health Loop* 2500 Peres. Memphis, TN 38108	Memphis City Schools Various Schools
Packer STD Clinic Room 221	South Memphis Health Loop* 1362 Mississippi Blvd. Memphis, TN 38106	Lead Program Home Setting Evaluations
Tuberculosis Clinic Room 111	Wellington Health Loop* 451 Linden Ave. Memphis, TN 38126	Community Nursing Home Setting Evaluations
Laboratory Room 258	Hickory Hill WIC/Immun. Clinic 6590 Kirby Center Cv. Memphis, TN 38117	Healthy Start Home Setting Evaluations
	Raleigh WIC/Immun. Clinic 3040 Covington Pike Memphis, TN 38128	Children's Special Services Home Setting Evaluations
	Southland Mall WIC/Immun. Clinic 1215 Southland Mall Memphis, TN 38116	Criminal Justice Center (CJC) 201 Poplar Ave.
	Galloway WIC/Immun. Clinic 757 Galloway Memphis, TN 38105	CJC - Jail East 1075 Mullins Station Rd.
	Shelby Crossing WIC/Immun. Clinic 6170 Macon Rd. Memphis, TN	Emergency Preparedness Shelter Various
		Emergency Preparedness Storage Sites Various
		Various MSCHD Programs 1075 Mullins Station Rd, 2nd Floor

* Joint agency Memphis-Shelby County Health Department and Regional Medical Center

RFP #08-011-32

ATTACHMENT B

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		Emergency Preparedness Storage Sites Various
		Various MSCHD Programs 1075 Mullins Station Rd, 2nd Floor

* Joint agency Memphis-Shelby County Health Department and Regional Medical Center

RFP #08-011-32

ATTACHMENT C

ALL ADDITIONAL PROFESSIONAL PERSONNEL CURRENTLY COVERED UNDER THIS PROGRAM (i.e., MD'S, FNP's, CNM's or PA's).

Name	Title
1. Regina F. Anderson	Nurse Practitioner
2. Nell Autry	Nurse Practitioner
3. Mary Bedwell	Nurse Practitioner
4. Donna Freeman	Nurse Practitioner
5. Judith A. Jones	Nurse Practitioner
6. Sandra N. Jones	Nurse Practitioner
7. Sandra S. Jones	Nurse Practitioner
8. Sheila Maclin	Nurse Practitioner
9. Margaret McCallum	Nurse Practitioner
10. Darlene Olive	Nurse Practitioner
11. Joyce Ann Thomas	Nurse Practitioner
12. Sharon H. Wright	Nurse Practitioner
13. Judy C. Martin, Ph.D	Nurse Practitioner
14. Vacant (To be filled 12/07)	Nurse Practitioner

ATTACHMENT D - 1

Please complete this form if the applicant is aware of any errors, omissions or claims as indicated in the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years.

1. Name of applicant:
   Shelby County Government Division of Health Services, D/B/A Memphis and Shelby County Health Department

2. Name of Member of Staff involved in claim:
   Regina F. Anderson, FNP.

3. Name of (potential) claimant:
   Jennifer Alexander, as next friend of Barbara Alexander

4. Date of Incident: 05/20/03 Date claim made: Lawsuit filed 06/07/04

5. Under which policy was the claim made? Carrier: ACE

   Policy No: MLP G21686670

6. Status of Claim: Closed:_____ Please indicate total loss ____
   or
   Open: X

7. Total defense costs and expenses to date:
   Fee Payment (see attached Loss Run)

8. Damages or other relief sought by the claimant(s): $15, 000,000

9. Insurers loss return: _____

10: Please the following details:

i) The specific act error or emission upon which the claimant bases the claim.
ii) A brief description of the claim,
iii) Details of the current status and proposed strategy for handling the claim.

   i) Alleged negligence in treatment
   ii) Misdiagnosis and treatment of aneurysm
   iii) Still pending: ACE claims specialist handling this is David Rapacioli

Please continue on another sheet if necessary…..

SIGNED:_____ DATE: _____

Please complete this form if the applicant is aware of any errors, omissions or claims as indicated in the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years.

1. Name of applicant:
   Shelby County Government Division of Health Services, D/B/A Memphis and Shelby County Health Department

2. Name of Member of Staff involved in claim:
   Dr. Arthur Gregory, M.D., no longer employed by Memphis and Shelby County Health Department.

3. Name of (potential) claimant:
   Robert Hill, patient at Wellington Clinic

4. Date of Incident: 05/2004 Date claim made: None yet filed

5. Under which policy was the claim made? Carrier: none

   Policy No: .

6. Status of Claim: none Closed : Please indicate total loss
   or
   Open X

7. Total defense costs and expenses to date: None

8. Damages or other relief sought by the claimant(s): none

9. Insurers loss return: none

10: Please the following details:

i) The specific act error or emission upon which the claimant bases the claim.
ii) A brief description of the claim,
iii) Details of the current status and proposed strategy for handling the claim.

   i) Dr. Hill called Mr. Hill's residence and informed his girlfriend that he had been diagnosed with a sexually transmitted disease
   ii) Violation of HIPAA regulations.
   iii) This matter has been submitted to State Volunteer Mutual Insurance for Professional Liability, the company which insures the physicians under a separate insurance policy.

Please continue on another sheet if necessary…..

SIGNED: DATE:

Loss Runs
Extracted 11/07/2007

Management = Medical - Facilities East;

Management: Medical - Facilities East
Marketing: Home Office

Claim Section	Policy Symbol Code	Policy Number	Insured Name	Claimant Name	Claim Rep Name	Claim Status	Claim Description	Event Date	Claims Made Dte	Claim Received Date	Section Description	Coverage Description	Indemnity Payment	Fee Payment	Indemnity Reserve	Gross Reserve
JY04J0052338-1	MLP	G21686670 001	Shelby County Government	alexander, barbara	Lebson, Daniel	Open	allege neg in dx and trtmnt r/i ventilator	05/20/2003	06/14/2004	06/14/2004	Med Prof Liab	MiscHlthCare Fac	$0.00	$218,525.73	$200,000.00	$200,000.00
													$0.00	**$218,525.73**	**$200,000.00**	**$200,000.00**

ATTACHMENT E-1

Loss Runs
Extracted 11/07/2007

Management = Medical - Facilities East;
Policy Number = G21686670 001;

Management: Medical - Facilities East
Marketing: Home Office

Claim Section	Policy Symbol Code	Policy Number	Insured Name	Claimant Name	Claim Rep Name	Claim Status	Claim Description	Event Date	Claims Made Dte	Claim Received Date	Section Description	Coverage Description	Indemnity Payment	Fee Payment	Indemnity Reserve	Gross Reserve
JY05J0143484-1	MLP	G21686670 002	Shelby County Government	Starter, Daniel	Honigman, Allen	Closed	Algd Q-tip broke off in trach tube	08/23/2005	08/29/2005	08/29/2005	Med Prof Liab	MiscHlthCare Fac	$0.00	$0.00	$0.00	$0.00
													$0.00	**$0.00**	**$0.00**	**$0.00**

ATTACHMENT E-2

ace usa

Memphis & Shelby County-Policy # MLP G21686670 003/004
As Of November 2007
Medical Risk Loss Data

POLICY NUMBER	EFF DATE	EXP DATE	EVENT DATE	REPORT DATE	CLOSE DATE	CLAIM DESCRIPTION	CLAIMANT NAME	PAID TOTAL	ALAE TOTAL	OUTST. TOTAL	TOTAL INC.	INSURED NAME	PRODUCER NAME

No Loss Data

ATTACHMENT E-3